



REQUIREMENTS FOR FILING AN APPLICATION FOR STERILE COMPOUNDING PHARMACY LICENSE

(Business & Professions Code Sections 4127 and 4127.1)

Effective July 1, 2003, a pharmacy may not compound injectable sterile drug products in California unless:

1. The pharmacy is specially licensed with the board as a sterile compounding pharmacy, OR:
2. The pharmacy is operated by an entity that is licensed by the board or the State Department of Health Services and has a current accreditation from the Joint Commission on Accreditation of Healthcare Organizations or another accreditation agency approved by the board (at the current time there is no other agency)

Nevertheless all pharmacies that compound injectable sterile drug products must follow board regulations for sterile compounding. These regulations are found in Title 16 of the California Code of Regulations as Article 8, beginning with section 1751.

Note: If a nonresident pharmacy is shipping injectable sterile drug products into California, the pharmacy must also comply with board regulations for sterile compounding. It also must be separately licensed by the board to compound injectable sterile drug products, unless it is operated by an entity that is licensed by the board or the State Department of Health Services and has a current accreditation from the Joint Commission on Accreditation of Healthcare Organizations or another accreditation agency approved by the board (at the current time there is no other agency). A separate application form for nonresident pharmacies is required and can be obtained from the board's Web site.

A license to compound injectable sterile drug products may only be issued to the owner of a licensed pharmacy at the licensed location. A license to compound injectable sterile drug products may not be issued until the location is inspected by the board and found to be in compliance with Article 7.5 of Chapter 9, of Division 2 of the Business and Professions Code and regulations adopted by the board.

For a complete application, the following items must be submitted:

1. A completed and signed Application for Sterile Compounding Pharmacy License (17A-48).
2. Fee of \$500, made payable to "Board of Pharmacy"
3. A copy of the pharmacy's proposed policies and procedures for sterile compounding on disk, CD, or via email. If emailing the policies and procedures, please send to CompoundingPharmacy@dca.ca.gov.

4. Corporate officer, owner, or partner who signed the application will need to complete the enclosed "Request for Live Scan Service" form.

Fingerprint Requirements

California Residents

The board will only accept Live Scan Service Forms from California residents.

Complete a Live Scan Request form and take all 3 copies to a Live Scan site for fingerprint scanning. Please refer to the Instructions for completing a "Request for Live Scan Service" form. Live Scan sites are located throughout California. For more information about locating a Live Scan site near you, visit the Department of Justice website at <http://caag.state.ca.us/app/contact.pdf> or the sources listed on the bottom of the instructions for completing a "Request for Live Scan Service" form.

The lower portion of the Live Scan Request form must be completed by the Live Scan operator verifying that your prints have been scanned and all applicable fees have been paid. Attach the second copy of the form to your application and submit to the board.

Non California Residents

If an owner, partner, corporate officer, major shareholder or director reside out of state they must submit rolled fingerprints on cards provided by the board and include a separate fee of \$42 (\$32 California Department of Justice (DOJ) processing fee and \$10 DOJ expedite fee). (Live Scan processing fees are paid directly at the Live Scan site.) You may contact the board to request fingerprint cards at (916) 445-5014. You may also request cards on our website at www.pharmacy.ca.gov.

Fingerprints submitted on cards should be taken by a person professionally trained in the rolling of prints. Fingerprint clearances from cards take approximately six weeks (live scan is faster). Poor quality prints may result in rejection and will substantially delay licensing as additional fingerprint cards will be required from you for processing.

The board will only accept fingerprint cards from residents outside of California.



California State Board of Pharmacy
400 R Street, Suite 4070, Sacramento, CA 95814-6237
Phone (916) 445-5014
Fax (916) 327-6308
www.pharmacv.ca.gov

STATE AND CONSUMER SERVICES AGENCY
DEPARTMENT OF CONSUMER AFFAIRS
ARNOLD SCHWARZENEGGER, GOVERNOR

APPLICATION FOR A STERILE COMPOUNDING PHARMACY LICENSE

Please print or type **ALL BLANKS MUST BE COMPLETED; IF NOT APPLICABLE, ENTER N/A**

Name of Pharmacy:			Pharmacy License Number	
Pharmacy Telephone Number:		Sterile Compounding Telephone Number: (if different)		
Address of Pharmacy:		Street and Number	City	State Zip Code

Name of pharmacist-in-charge of licensed pharmacy:			Pharmacist license number	
Residence address:		Street and Number	City	State Zip Code

Indicate whether this application is for:		
<input type="checkbox"/> New Licensed Sterile Compounding License	<input type="checkbox"/> Change of Location of Licensed Sterile Compounding pharmacy	<input type="checkbox"/> Change of Ownership of Licensed Sterile Compounding pharmacy
If this is a change of ownership or change of location , indicate previous name, address and license number of compounding pharmacy.		
Name:	Address:	License Number:
Please indicate type of ownership:		
<input type="checkbox"/> Individual	<input type="checkbox"/> Partnership	<input type="checkbox"/> Corporation <input type="checkbox"/> Not-for-profit corporation <input type="checkbox"/> Government owned

I certify that the policies and procedures of the sterile compounding are consistent with California Code of Regulations Title 16, section 1751 et seq. (Please include electronic version of procedures with this application)

Signature of Pharmacist-in-Charge

Name (please print)

Date

CONTINUE ON REVERSE

FOR OFFICE USE ONLY		
STAFF REVIEW		CASHIER LOG
<input type="checkbox"/> _____ <input type="checkbox"/> _____	Approved _____	Cashier # _____
<input type="checkbox"/> _____ <input type="checkbox"/> _____	Denied _____	Date _____
Referred for inspection: _____	Date _____	Amount of fee _____
Inspection Completed: _____		

Ownership Information

If a Sole Ownership:				
Name of Sole Owner		*Social Security Number		Telephone Number
Address number and street		City	State	Zip Code
If a Partnership: (attach additional sheet if needed)				
Name of Partner		*FEIN Number		Telephone Number
Address number and street		City	State	Zip Code
Name of Partner		*FEIN Number		Telephone Number
Address number and street		City	State	Zip Code
If a Corporation: (attach additional sheet if needed)				
Name of Corporation (If applicable)				Telephone Number
Address number and street		City	State	Zip Code
<p>Print below the name, title, address and license number of all the pharmacy owners. This includes the individual owner, all partners, corporate officers. Under the heading "Licensed as" list any state professional or vocational licenses held; e.g., pharmacist, physician, podiatrist, dentist or veterinarian etc., and license number. Non-profit organizations must list the names and titles of persons holding corporate positions. Attach additional sheets if necessary.</p>				
Title	Name	Residence Address	Social Security Number	Licensed as and license number

*Disclosure of your social security number (or federal employer identification number ("FEIN"), if you are a partnership) is mandatory. Section 30 of the Business and Professions Code and Public Law 94-455 (42 USCA 405(c)(2)(C)) authorize collection of your social security number. Your social security number or FEIN will be used exclusively for tax enforcement purposes or compliance with any judgment or order for family support in accordance with section 17520 of the Family Code. If you fail to disclose your social security number or your FEIN, your application for initial or renewal license will not be processed AND you may be reported to the Franchise Tax Board, which may assess a \$100 penalty against you.

*Federal Employer Identification Number

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PLEASE READ CAREFULLY

This application must be approved by the California State Board of Pharmacy before a Sterile Compounding License will be issued.

If changes are made during the application process, you may need to submit a new application with the appropriate fees. **Any application not completed within 60 days after you have been notified by the board of deficiencies in your file, may be deemed to have been abandoned, and you may be required to file a new application and meet all the requirements which are in effect at the time of application. Fees applied to this application are not transferable and are not refundable.**

Any material misrepresentation in the answer of any question is grounds for refusal or subsequent revocation of a license, and is a violation of the Penal Code of California. All items of information requested in this application are mandatory. Failure to provide any of the requested information will result in the application being rejected as incomplete.

The information will be used to determine qualifications for licensure under California Pharmacy Law. The officer responsible for information maintenance is the Executive Officer, (916) 445-5014, 400 R Street, Suite 4070, Sacramento, California 95814. The information may be transferred to another governmental agency (such as a law enforcement agency) if necessary for it to perform its duties. Each individual has the right to review the files or records maintained on him/her by the Board of Pharmacy, unless the records are identified as confidential information and exempted from disclosure by the California Information Practices Act. (Civil Code §1798, et seq.)

Under penalty of perjury, under the laws of the State of California, the person whose signature appears below, certifies that: (1) he/she is the owner or an officer of the applicant corporation named in the foregoing application, duly authorized to make this application on its behalf and is at least 18 years of age; (2) he/she has read the foregoing application and knows the contents thereof and that all statements therein made are true; (3) no person other than the applicant has any direct or indirect interest in the applicant's business to be conducted under the license(s) for which this application is made; (4) all supplemental statements are true and accurate; I am also aware that I am bound by the applicable federal and state laws and regulations pertaining to the practice of pharmacy.

Signature of corporate officer, owner, or partner	Name (please print)	Title	Date
Mail all correspondence to the following address below. If correspondence should be mailed to the pharmacy please insert "Same as Pharmacy."			
Name and telephone number of contact person to clarify information provided on this application. ()		e-mail address	

**INSTRUCTIONS FOR COMPLETING A
"REQUEST FOR LIVE SCAN SERVICE" FORM
(California Residents)**

The following instructions are provided to assist you in completing this form accurately. Please follow all instructions carefully and print clearly; failure to do so may result in processing delays of your application.

1. **Job Title or Type of License, Certification, or Permit:** Enter the type of license, certification or permit for which you are applying. Appropriate license types include pharmacist, pharmacy technician, intern pharmacist, exemptee, or if an owner or officer of a pharmacy, hospital, clinic, wholesaler or hypodermic permit enter appropriate title of the facility.
2. **Name of Applicant:** Enter your last name, first name and middle name. Do not use initials or name abbreviations.
3. **AKA:** Enter all other names you have used, including your maiden name.
4. **CDL No:** Your California Driver's License Number.
5. **DOB:** Your date of birth (month/day/year).
6. **SEX:** Your gender (male or female).
7. **HT:** Your height in feet and inches.
8. **WT:** Your weight in pounds.
9. **Misc. No.:** Enter other identifying numbers. (e.g., Other State Driver's License Number)
10. **EYE Color:** Color of your eyes
11. **HAIR Color:** Color of your hair
12. **Home Address:** Your residence address
13. **POB:** Enter your place of birth.
14. **SOC:** Enter your Social Security Number

Take the completed form to your nearest Live Scan site for fingerprint scanning. There are more than 130 Live Scan sites throughout the state. An up-to-date Live Scan site list is on the Department of Justice's (DOJ) Internet web page at <http://caag.state.ca.us/app/contact.pdf> or call your local police or sheriff's department.

Contact the live scan service for hours of operation, an appointment (if necessary), acceptable forms of payment and identification requirements. Be prepared to pay **ALL applicable fees** (the DOJ processing fee of \$32 and fingerprint scanning service fee) at the time your prints are taken. The live scan fingerprinting service fee varies from about \$5 to \$20. The cost to electronically submit your fingerprints is determined by the local Live Scan agency and the agency can charge a fee sufficient to recover its costs.

The lower portion of the Request for Live Scan Service form must be completed by the live scan operator. The original of the form is retained by the scanning service; the second copy is to be attached to your application and submitted to the board; and the third copy is for your records.

FINGERPRINTING AUTHORITY

Section 144(b) of the Business and Professions Code authorizes the Board of Pharmacy to require an applicant for licensure to furnish a full set of fingerprints for purposes of conducting criminal history record checks. Fingerprints are required in order for the DOJ to conduct background checks for criminal convictions.

REQUEST FOR LIVE SCAN SERVICE

Applicant Submission

ORI: _____ Type of Application: (check one) ☐ Employment ☐ License, Certification, Permit ☐ Volunteer
Code assigned by DOJ
Job Title or Type of License, Certification or Permit: _____

Agency Address Set Contributing Agency:

_____		_____
Agency authorized to receive criminal history information		Mail Code (five-digit code assigned by DOJ)
_____		_____
Street No.	Street or PO Box	Contact Name (Mandatory for all school submissions)
_____		()
City	State	Zip Code
		Contact Telephone No.

Name of Applicant: _____
(Please print) Last First Middle

AKA's: _____ CDL No. _____
Last First

DOB: _____ SEX: ☐ Male ☐ Female Misc. No. **BIL** - _____
Agency Billing Number (if applicable)

HT: _____ WT: _____ Misc. No. _____

EYE Color: _____ HAIR Color: _____ Home Address: _____

POB: _____ Street or PO Box _____

SOC: _____ City, State and Zip Code _____

Your Number: _____
OCA No. (Agency Identifying No.)

Level of Service DOJ ☐ FBI ☐

If resubmission, list Original ATI No. _____

Employer: (Additional response for Department of Social Services, DMV/CHP licensing, and Department of Corporations submissions only)

Employer Name

Street No. Street or PO Box Mail Code (five digit code assigned by DOJ)

()

City State Zip Code Agency Telephone No. (Optional)

Live Scan Transaction Completed By: _____ Date _____
Name of Operator

Transmitting Agency ATI No. Amount Collected/Billed

REQUEST FOR LIVE SCAN SERVICE

Applicant Submission

ORI: _____ Type of Application: (check one) ☐ Employment ☐ License, Certification, Permit ☐ Volunteer
Code assigned by DOJ
Job Title or Type of License, Certification or Permit: _____

Agency Address Set Contributing Agency:

_____		_____	
Agency authorized to receive criminal history information		Mail Code (five-digit code assigned by DOJ)	
_____		_____	
Street No.	Street or PO Box	Contact Name (Mandatory for all school submissions)	
_____		() _____	
City	State	Zip Code	Contact Telephone No.

Name of Applicant: _____
(Please print) Last First Middle

AKA's: _____ **CDL No.** _____
Last First

DOB: _____ **SEX:** ☐ Male ☐ Female **Misc. No.** **BIL -** _____
Agency Billing Number (if applicable)

HT: _____ **WT:** _____ **Misc. No.** _____

EYE Color: _____ **HAIR Color:** _____ **Home Address:**

POB: _____ Street or PO Box

SOC: _____ City, State and Zip Code

Your Number: _____
OCA No. (Agency Identifying No.)

Level of Service DOJ ☐ FBI ☐

If resubmission, list Original ATI No. _____

Employer: (Additional response for Department of Social Services, DMV/CHP licensing, and Department of Corporations submissions only)

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() _____

City State Zip Code Agency Telephone No. (Optional)

Live Scan Transaction Completed By: _____ **Date** _____
Name of Operator

Transmitting Agency ATI No. Amount Collected/Billed

REQUEST FOR LIVE SCAN SERVICE

Applicant Submission

ORI: _____ Type of Application: (check one) ☐ Employment ☐ License, Certification, Permit ☐ Volunteer
Code assigned by DOJ
Job Title or Type of License, Certification or Permit: _____

Agency Address Set Contributing Agency:

_____		_____
Agency authorized to receive criminal history information		Mail Code (five-digit code assigned by DOJ)
_____	_____	_____
Street No.	Street or PO Box	Contact Name (Mandatory for all school submissions)
_____	_____	() _____
City	State	Zip Code
		Contact Telephone No.

Name of Applicant: _____
(Please print) Last First Middle

AKA's: _____ CDL No. _____
Last First

DOB: _____ SEX: ☐ Male ☐ Female Misc. No. **BIL** - _____
Agency Billing Number (if applicable)

HT: _____ WT: _____ Misc. No. _____

EYE Color: _____ HAIR Color: _____ Home Address: _____

POB: _____ Street or PO Box _____

SOC: _____ City, State and Zip Code _____

Your Number: _____
OCA No. (Agency Identifying No.)

If resubmission, list Original ATI No. _____

Level of Service DOJ ☐ FBI ☐

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Employer Name

Street No. Street or PO Box Mail Code (five digit code assigned by DOJ)

() _____

City State Zip Code Agency Telephone No. (Optional)

Live Scan Transaction Completed By: _____ Date _____
Name of Operator

Transmitting Agency ATI No. Amount Collected/Billed